of sera of four patients after removal of the thyroid gland. In two of these there was marked postoperative clinical improvement, and the test became negative within fifteen to thirty days after operation. The author advances some hypotheses as to the nature of the reaction, but admits that the evidence at present is far too meager to permit of any definite conclusions.

SURGERY

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Valve Formation in the Urinary Bladder for the Escape of Ascitic Fluid.—ROSENSTEIN (*Zentralbl. f. Chir.*, 1914, xli, 373) conceived and put into practice the idea of permitting the ascites, due to liver cirrhosis, to escape into the urinary bladder. A woman, aged sixty-two years, suffered from liver cirrhosis and ascites since 1911. Rosenstein made an anastomosis between the portal vein and the inferior cava, *i. e.*, an Eck fistula. Unfortunately the success was only temporary. Later he did a Talma operation (suturing the spleen and great omentum to the abdominal wall and painting the surface of the liver with tincture of iodine), but this was also unsuccessful. In June, 1913, he did the following operation: The abdomen was opened freely and the whole peritoneal covered portion of the bladder exposed. He then drew a portion of the summit of the bladder through a silver ring, 3 cm. in diameter, cut the apex of this portion of the bladder with a scissors, and turned the margins over the ring all around so that the serosa was applied to serosa and fixed it in this position by silk sutures. This gave a free communication between the bladder and peritoneal cavity. He then excised a strip of the serosa and muscularis of the bladder wall all around below the ring and silk sutures, leaving only the mucosa. The upper and lower margins of this raw surface were sutured together, muscularis to muscularis and serosa to serosa. This forced the mucosa layer inward in the form of a circular double layer which, when the bladder was allowed to drop into place, acted as a valve to prevent the escape of urine into the peritoneal cavity. But it permitted the ascitic fluid to make its way into the bladder. The operation also provided against leaving any sutures in the mucosa, which is important in all bladder operations. The abdominal wound was closed, primary healing occurred, and after a short time the patient left her bed. The ascitic fluid passed out with the urine, and the cystoscope showed that the valve functionated perfectly. The cure was not complete, as the ascitic fluid had to be withdrawn by puncture about every eight weeks, whereas before the first operation it was done about every eight days.

Thirteen Years' Experience with Pyloroplasty.—FINNEY and FRIEDENWALD (*Surg. Gyn. and Obst.*, 1914, xviii, 273) present their results with this operation, which Finney introduced in 1902, and a discussion of its advantages and disadvantages. The records of 100 cases, in which the operation was done, were studied. Of the 100 cases, the final results in 17 are unknown, while 5 died soon after operation, leaving 78 cases, in which the average percentage of favorable satisfactory recoveries was 93.8 per cent., the later deaths, 5 per cent., or favorable results 88.8 per cent. The operation has its greatest indication in the relief of pyloric stenosis, due to chronic ulcers, situated at or near the pylorus, and on either side of it or resulting from cicatricial contraction following the healing of such ulcers. It is often a useful procedure in cases of hemorrhage due to gastric ulcers on the lesser curvature or to duodenal ulcers which cannot be controlled medically, and which threaten the life of the patient, as well as in the chronic dyspepsias due to ulcers which have not been relieved by medical treatment. The operation has certain advantages over gastro-enterostomy and few of its disadvantages. Such objections as are advanced against the operation, *e. g.*, its inapplicability in the presence of active and bleeding ulcers, and also because of the fact that the new opening is not at its lowest point, taking advantage of gravity, are, according to their experience, more fanciful than real, since the operation has frequently been performed under these circumstances with most gratifying results. The interesting experimental work of Cannon and Blake and others supports this contention. The only contra-indications to the operation are inability to mobilize the duodenum when adhesions are too dense, and thickening and infiltration about the pylorus due to hypertrophic forms of ulceration. These are rare, however. In atony or gastroptosis with slight motor insufficiency such as observed in the water-trap stomach, or in nervous dyspepsia, *i. e.*, in gastric disturbances not dependent upon organic disease, this operation is contraindicated. The special advantages lie in its affording the opportunity to excise all ulcers in the anterior walls of the stomach or duodenum after direct inspection of the part affected; also the application of treatment to ulcers situated in the posterior walls. It does not greatly disturb the normal relation between the stomach and intestines, as is the case in other operations. From their experience the immediate as well as the final results are most encouraging, while in some instances partial gastrectomy or gastro-enterostomy is undoubtedly the operation of choice; nevertheless, on account of its simplicity and satisfactory end results, they believe that pyloroplasty will continue to retain its position as a safe and useful procedure.

The Direct Implantation of Nerves into Muscles.—HEINEKE (*Zentralbl. f. Chir.*, 1914, xli, 465) experimented on the hind legs of rabbits. The two branches of the sciatic nerve, the internal and the external